

Office of Environment, Safety and Health

LLNL and WIPP Enforcement Actions

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Introduction

- ✓ LLNL Site-Wide Investigation
- ✓ LNL MOVER Investigation
- ✓ WIPP MOVER Investigation



LLNL Site-Wide Investigation Background

- **✓ LLNL Program Review 2004**
 - Significant weaknesses observed
- **✓ LLNL Follow-up Program Review 2005**
 - No improvements observed
- **✓** Multiple DOE/NNSA Reviews 2004/2005
 - Many longstanding nuclear safety issues



LLNL Site-Wide Investigation Background (cont'd)

- **✓** Super Block Stand-down January 2005
- ✓ NNSA HQ, LSO, and OE expand scope of ongoing MOVER investigation
- **✓** Phosphorous-32 Spill Event April 2005



LLNL Site-Wide Investigation

✓ Focused on Problems in the Following Areas:

- Phosphorous-32 Spill Event
- Radiation Protection Program
- Configuration Management Program(Safety Basis and Design Control)
- USQ Program Implementation
- Quality Improvement Processes



LLNL Site-Wide Investigation Phosphorous-32 Spill Event

✓ Key Factors Considered:

- Inadequate spill response
- Unauthorized/uncontrolled removal of radioactive material from site
- Technical Expert/supervisor involvement



LLNL Site-Wide Investigation Radiation Protection Program

✓ Key Factors Considered

- No formal process to capture work place radiological deficiencies
- Lack of required ALARA reviews
- Failures to track and correct 835 audit findings
- Some of the above deficiencies considered event precursors



LLNL Site-Wide Investigation Configuration Management Program

✓ Key Factors Considered

- Multiple TSR Violations Specific system and program issues
- Design Control and Documentation Issues Recent facility modification deficiencies
- Failure to complete baseline vital system walk downs and assessments



LLNL Site-Wide Investigation USQ Program Implementation

✓ Key Factors Considered

- Failures to address Discrepant-as-Found Conditions (DAFC via USQ PISA process)
- Multiple longstanding documentation issues
- Failure to adequately screen per procedures
- Multiple NTS Reports



LLNL Site-Wide Investigation Quality Improvement Process

✓ Key Factors Considered

- Longstanding and recurring nature of many noncompliances
- Causal analysis process limited to very high level events and a lack of a defined process
- No integrated approach to corrective action management



MOVER Overview

- ✓ Involved chronic radiological uptakes during TRU Waste glovebox operations
- ✓ Occurred at LLNL but in a WIPP controlled and operated mobile facility
- ✓ Project started with surplus equipment from LANL, transferred to WIPP, with unresolved quality problems



MOVER





MOVER





MOVER





LLNL MOVER Investigation

Focused On:

- ✓ Facility Readiness Activities
- ✓ LLNL Radiation Protection Services
- ✓ Safety Basis Implementation
- ✓ DOE perceived weaknesses in LLNL event investigation and recommended actions



LLNL MOVER Investigation (cont'd)

✓ Key OE Investigation Results

- Inadequate system testing and lack of limits on equipment operability
- Mismatch of radiological controls with facility conditions
- Ineffective LLNL response to the changing radiological conditions



LLNL MOVER Enforcement Action

✓ Key Factors Considered

- Multiple breakdowns in the development of radiological controls
- Several missed opportunities by technical experts and supervision to identify and control the hazards
- Potential consequences could have been greater



LLNL Site-Wide Enforcement Action (cont'd)

- ✓ One SL III, Three SL II, and Two SL I
- ✓ Only Limited Mitigation for the SL II's
 - 25% for corrective action
 - None for reporting
- ✓ Two Quality Improvement Violations Escalated



LLNL MOVER Enforcement Action (cont'd)

✓ Three Severity Level II Violations

✓ Only Limited Mitigation

- Weaknesses in initial causal analysis and corrective action plans
- Deficiencies were disclosed by the event



WTS MOVER Investigation

Focused On:

- ✓ Safety Basis Development Issue
- ✓ Control of Design and Operational Interfaces
- ✓ WTS Response to Abnormal Conditions
- ✓ WTS's limited response to the event



WTS MOVER Investigation (cont'd)

✓ OE Key Investigation Results

- Safety Basis development inappropriately passed to host sites
- Design related quality issues not adequately resolved
- Inadequate abnormal condition response (ventilation alarms, high surface contamination, chronic airborne levels)



WTS MOVER Enforcement Action

✓ Key Factors Considered

- WTS initial investigation inadequate
- Safety Basis and design issues resulted in a limited understanding of system performance prior to use
- Operational experience at ANL-E not carried forward to LLNL



WTS MOVER Enforcement Action (cont'd)

✓ Four Severity Level II Violations

- **✓** Only Limited Mitigation
 - Weaknesses in initial causal analysis and corrective action plans
 - Deficiencies were disclosed by the event